Useful resources for patient safety

CQC and GMC links

The CQC says the following about patient safety:

- Recording patient safety events indicates a positive safety culture, encourages staff to be open and honest when things go wrong and can proactively improve safety.
- We expect practices to have a local process to record and learn from minor incidents and events.
- Primary care staff are encouraged to use the learn from patient safety events (LFPSE) system. This is only available in England.
- A notifiable safety incident must meet all three of the following criteria:
    - It must have been unintended or unexpected.
    - It must have occurred during the provision of an activity regulated by the CQC.
    - In the reasonable opinion of a healthcare professional, it already has, or might, result in death, or severe or moderate harm to the person receiving care.

The following links should be useful for practices who are preparing for a CQC inspection and want to be proactive about patient safety.

Regulation 12: safe care and treatment
Regulation 20: duty of candour
Learning from safety incidents
Duty of candour: notifiable safety incidents
Raising and acting on concerns about patient safety (GMC document)

BMA guidance

This link has guidance from the GP committee England (GPCE) of the BMA and includes links to template letters which practices can use to push back on the unresourced workload which takes up time in general practice, reducing the amount of time that we have to provide safe care to our own patients.

Safe working in general practice in England (BMA guidance)

NHSE primary care patient safety strategy

Applicable to England only, the primary care patient safety strategy was launched in September 2024. It aims to develop a supportive learning environment, where the approach to managing safety is systematic. It is not currently contractual on ICBs or GP practices, but those who wish to know more can look at the links below.

Primary care patient safety strategy
Information about LFPSE (Learn From Patient Safety Events)
Sign up for an LFPSE account
NHSE patient safety strategy
PSIRF (Patient Safety Incident Response Framework)
Related training modules from elearning for healthcare

Patient safety resources for the devolved nations

GPs working in the devolved nations of the UK may find the following links useful.

NHS Education for Scotland Patient Safety Zone
Patient Safety Wales
Department of Health, Northern Ireland. Safety and quality

Reflection models

The following resources give further information on reflection.

GP appraisals and revalidation
Revalidation Wales – reflective practice

Health Education England – models of reflection and reflective practice
NHSE information on written reflective practice – response to the Hadiza Bawa-Garba case

Patient safety questionnaire
Send this questionnaire, instruction sheet and covering letter to a randomly selected group or patients, to ask about their experience of patient safety at a practice.
Questionnaire
Instruction sheet
Covering letter

Checklists for use in practice
The concise safe systems checklist is designed to capture aspects of patient safety which are not tested by systems such as CQC inspections. The safety checklist for general practice, designed by NHS Education for Scotland in partnership with Health Improvement Scotland, is longer and covers wider system issues, many of which are mandatory requirements for practices.
Concise safe systems checklist
Safety checklist for general practice

Significant event analysis (SEA) framework
For the purposes of appraisal, an SEA is the learning response to any event in which a patient/patients came to harm or could have come to harm. Practices may want to use this short framework to discuss other events from which learning can be taken, even if no harm occurred or could have occurred. For those who want more detailed information, the guide may be useful.
CQC information on SEAs
RCGP guide on reporting and learning from patient safety incidents in general practice
SEA framework

Some publications around patient safety
Those wanting to learn more might want to review some of these papers.
Using sociotechnical theory to understand medication safety work in primary care and prescribers' use of clinical decision support: a qualitative study
Harms from discharge to primary care: mixed methods analysis of incident reports
Nature of Blame in Patient Safety Incident Reports: Mixed Methods Analysis of a National Database
Pediatric immunization-related safety incidents in primary care: A mixed methods analysis of a national database
Sources of unsafe primary care for older adults: a mixed-methods analysis of patient safety incident reports
Quality improvement priorities for safer out-of-hours palliative care: Lessons from a mixed-methods analysis of a national incident-reporting database
Patient safety incidents in advance care planning for serious illness: a mixed-methods analysis
A mixed-methods analysis of patient safety incidents involving opioid substitution treatment with methadone or buprenorphine in community-based care in England and Wales